Macomb Family Services, Inc.
Client Self Report

Client Name:_____ Date: _____

Client Social Security #: _____

Form completed by (if someone other than client)_____

Address:_____

City: _____State: _____Zip: _____

Phone (Home) _____(Work)_____ DOB____/____/____ Age _____

May the agency/therapist contact you at home? Yes ___ No ___ Work? Yes___ No ___

Why are you requesting counseling? What do you see as the main issue?

_____

_____

Symptom Checklist: (check all that apply)

- ❑ Anger
- ❑ Anxious
- ❑ Appetite changes
- ❑ Bedwetting
- ❑ Compulsive behaviors
- ❑ Delusions
- ❑ Depressed mood
- ❑ Difficulty with life changes
- ❑ Difficulty concentrating
- ❑ Distinctive behaviors
- ❑ Fire-setting
- ❑ Flashbacks
- ❑ Hallucinations
- ❑ Hopelessness
- ❑ Hyperactivity
- ❑ Impulse control
- ❑ Lack of interest in activities
- ❑ Legal problems
- ❑ Loss/Grief
- ❑ Mania
- ❑ Nightmares/Night terrors
- ❑ Obsessive thoughts
- ❑ Oppositional behaviors
- ❑ Panic attacks
- ❑ Phobias
- ❑ Sexual difficulties
- ❑ Sleep related disorders
- ❑ Past substance use/abuse
- ❑ Current substance use/abuse
- ❑ Suicidal/Homicidal ideations
- ❑ Tearful
- ❑ Weight changes
- ❑ Worrisome
- ❑ Other

If you have other symptoms not listed above, please describe.

_____

_____

Have any of the above symptoms been present for more than a year?

_____

_____

What would you like to accomplish during treatment?

_____

_____

COUNSELING AND PRIOR TREATMENT

Please list all previous treatment experiences.

Type of Treatment	Yes	No	Approx month & year	# Of times	Where	List any Meds prescribed	If taken, Meds effective?		Outcome
Counseling/Psychiatric Treatment							☐ Yes ☐ No	☐ N/A ☐ Some what	
Alcohol/Drug Treatment							☐ Yes ☐ No	☐ N/A ☐ Some what	
Hospitalizations							☐ No ☐ Yes	☐ N/A ☐ Some what	
Self-help groups: AA, Al-Anon, ACOA, Overeaters, Other(s): _____						N/A	N/A		

Have you experienced any of the following?

Current	Past	No		Current	Past	No	
❑	❑	❑	Severe childhood illnesses	❑	❑	❑	Problems in school
❑	❑	❑	Physical Abuse	❑	❑	❑	Trauma from crime
❑	❑	❑	Sexual Abuse	❑	❑	❑	Emotional difficulty due to divorce
❑	❑	❑	Emotional Abuse	❑	❑	❑	Sibling conflicts
❑	❑	❑	Neglect	❑	❑	❑	Parenting problems
❑	❑	❑	Protective Service Involvement	❑	❑	❑	Physical / Domestic violence

Has a family member or close friend of yours ever attempted or committed suicide? Yes ❑ No ❑

Family Member or Friend	Attempted / Committed	When & How

Have you ever experienced any suicidal thoughts? Yes ❑ No ❑ ❑Current ❑Past Age:_____
If yes, do you have them currently? Please provide some detail about your suicidal thoughts.

_____

Have you ever attempted suicide? Yes ❑ No ❑ ❑Current ❑Past Age:_____ # times____
most recent date_____ method(s) used_____

Describe what happened: _____

_____

_____

Have you experienced any homicidal thoughts? Yes ❑ No ❑ ❑Current ❑Past Age:_____
If yes, please describe; and if they are current, please provide some details.

_____

Have you ever acted on these thoughts? Yes ❑ No ❑
If yes, list how many times, the most recent date, and the method (s) used.

_____

Have you ever assaulted anyone? Yes ❑ No ❑
If yes, list how many times, and include the dates and how the assault(s) happened.

_____

PHYSICAL & MEDICAL HISTORY REVIEW

Do you have any history of head injuries? ❑ Yes ❑ No If yes, at what age: _____

I currently receive treatment for physical symptoms, pain, and/or an impairment or disability. ❑ Yes ❑ No

Do you have any known drug or other allergies? ❑ Yes ❑ No

If Yes, please list: _____

Last physical exam: Date: _____ Performed by: _____

Address of Personal Physician: _____

_____Telephone No. _____

Do you have any disabilities that require special accommodation? ❑ Yes ❑ No If yes, please identify:

_____

How would you describe your health? ❑Excellent ❑Good ❑Fair ❑Poor □

Have you ever had any seizures? ❑ Yes ❑ No If Yes, when_____

Have you ever had surgery? ❑ Yes ❑ No If Yes, when: _____

Are you pregnant? ❑ Yes ❑ No If Yes, when is your expected due date: _____

Do you have access to medical insurance? ❑ Yes ❑ No

Please list past or present illnesses & medical conditions & describe impact on functioning		Are you currently being treated?	
Illness or Condition	Impact on your activities of daily living:	YES	NO

Have you experienced or been treated for any of the following problems?

- ❑ Alzheimer/Dementia
- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer
- ❑ COPD
- ❑ Crohn Disease
- ❑ Cystic Fibrosis
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Heart Disease
- ❑ Multible Sclerosis
- ❑ Parkinsons
- ❑ Pancreatitis
- ❑ Other

If Other, please list: _____

Please list your current medications, including prescription and over the counter (OTC) medications.

Medication	Dosage	RX Date	Doctor	Reason

FAMILY INFORMATION								
	Name	Current Age	Deceased		Your age then	Living with you now?	
			Yes	No		Yes	No
Mother							
Father							
Spouse							
Children							
Siblings							

Has anyone in your family ever been diagnosed with a mental illness? Yes ❑ No ❑

Family Member	Type of Illness	When

Current Marital Status: (check all that apply)

❑ Single ❑ Married # Marriages: _____ Length of time married _____❑ Single ❑ Divorced
❑ Annulment ❑ Widowed ❑ Unmarried, living w/partner ❑ Divorce in progress

Assessment of current relationship: ❑ Good ❑ Fair ❑ Poor ❑ N/A
Do you have any conflicts with family members? ❑ Yes ❑ No If yes, please explain.

_____

Parent Information: Check all that apply and fill in blanks as applicable.

❑ Parents were legally married ❑ Mother remarried: Number of times _____
❑ Parents were separated ❑ Father remarried: Number of times_____
❑ Parents were divorced. [Your age:_____] ❑ I was adopted and/or placed in foster homes.
❑ I was raised by a family member other than my birth parent_____my age_____

Please list any other information that your therapist may find helpful in treating you. For example, if you were raised outside the home by grandparents, other family members, or foster homes, etc., please explain: _____

_____

_____

Do you have family members or close friends with an alcohol or drug problems? Yes ❑ No ❑
Have you ever lived with someone who has an alcohol/substance abuse problem? Yes ❑ No ❑
Do you wish to have any family members or close friends involved in your treatment? Yes ❑ No ❑
If so, who?_____

RECREATION & LEISURE

Has your activity level changed in the last 6 months? Yes ❑ No ❑
If yes, please describe: _____
Which of the following activities do you participate in on a regular basis?
Please list: _____

_____

SPIRITUAL & RELIGIOUS MATTERS

Do you consider yourself a spiritual person? Yes❑ No❑
If yes to the above, what religion were you raised in and what religion do you practice now?

_____

Do you have any spiritual/religious issues that may affect your treatment? Yes ❑ No ❑
If yes, explain_____

EMPLOYMENT

Are you satisfied with your current job? Yes ❑ No ❑

What is the longest period of time that you have held a job? _____

Check all that apply

❑ Employed full-time ❑ Laid off ❑ On Medical Disability ____ Long term____ Short Term
❑ Employed part-time ❑ Retired ❑ In the process of Applying for Disability
❑ Currently unemployed ❑ Homemaker ❑ Suspended

Are you experiencing financial problems that are impacting your mental health issues?

Yes ❑ No ❑ If yes, explain_____

For purposes of funding and setting the service fees, please complete the following.

Family Member	Employer	Dates of Employment	Annual Income
Client			**$**
Client's Spouse			**$**
Other Sources of Income			**$**
		Total Household Income	**$**

CULTURAL / ETHNIC

What is your family's cultural or ethnic background? _____

Does your cultural or ethnic background significantly impact your life? Yes ❑ No ❑

EDUCATION

❑ Earned high school diploma (year) _____ ❑ Earned G.E.D. (year) _____
❑ Did not complete high school. Last grade completed _____
❑ Currently attending college or university: year_____ College degree_____
❑ Major or field of study _____
❑ Vocational training ❑ Currently enrolled ❑ Training completed, Specialty: _____
Please list any degrees or professional or technical certifications: _____

_____

Are you interested in furthering your education? Yes ❑ No ❑

Do you have special circumstances that affect your education? (For example, a history of ADD/ADHD, learning disabilities, gifted program, alternative or special education, etc.)

_____

_____

MILITARY

Military experience? Yes ❑ No ❑ When? _____Where? _____

Combat experience? Yes ❑ No ❑ When? _____Where? _____

Date enlisted:_____ Branch:_____ Discharge Date: _____

Type of discharge: _____ Rank at discharge: _____

LEGAL

Have you been referred to ***MFS*** by Court Order? Yes ❑ No ❑ If yes, court:_____

Have you been referred to ***MFS*** by DHS? Yes ❑ No ❑ Worker's Name_____

Name & Address of court (if applicable)_____

Have you ever been, or are you now involved in any of the following legal or court proceedings?

Drunk Driving	Yes ❑ No ❑	Currently on Probation/Parole	Yes ❑ No ❑
Assault Crime	Yes ❑ No ❑	Civil Case	Yes ❑ No ❑
Workman's Comp	Yes ❑ No ❑	Juvenile Court	Yes ❑ No ❑
Bankruptcy	Yes ❑ No ❑	DHS	Yes ❑ No ❑

If yes please complete the following:

Type of Case, charge, arrest, etc.	Date	Where (city)	Result

COMPULSIVE BEHAVIOR

Have you experienced any of the following behaviors that you would consider compulsive or addictive?

❑ Cleaning	❑ Internet	❑ Shopping
❑ Eating	❑ Pornography	❑ Work
❑ Gambling	❑ Sex	❑ Other

Comments:

SOCIAL

S: Describe your strengths (external items, like good family support, strong educational performance, etc.):

N: What are your needs?

A: What are your abilities (positive internal qualities, such as intelligent, hardworking, etc.)

P: What are your preferences with respect to services?

Who are the (3) people you feel closest to? _____

Do you isolate yourself from others? Yes ❑ No ❑ If yes, please explain:

Do your social activities include the use of drugs or alcohol? Yes ❑ No❑ If yes, please explain:

Sexual Orientation:

___ Heterosexual (attracted to opposite sex) ___ Bisexual (attracted to both sexes)

___ Homosexual (attracted to the same sex) ___ Confused / Not sure

Do you have concerns about your sexuality that you would like to discuss with your therapist?

Yes ❑ No ❑ If yes, please explain._____

CHEMICAL USE HISTORY

Please fill this chart out completely as possible. Include all substances used in the past and present.

Current Age _____	Age of first use	Age of last use	Method of use				Amount	How Often?	Used in last 48 hours		Used in the last 30 days	
			Oral	Injecton	Smoke	Inhale			Yes	No	Yes	No
Caffeine												
Nicotine												
Alcohol												
Barbiturates												
Benzo / Xanax												
Cocaine/Crack												
Heroin/Opiates												
Marijuana												
Hallucinogens												
Inhalants												
Other												

Has anyone ever told you that alcohol and/or drug use are causing you problems? Yes ❑ No ❑

If so, Whom? _____

Have you ever sought help for alcohol and/or drug problems? Yes ❑ No ❑

If so, when? _____

What is your drug/substance of choice?_____When did you last use? _____

How much did you use on that date? _____

Do you drink or use drugs more then you did last year? Yes❑ No❑ How much? _____

Has drinking or drug use ever caused problems in your life? Yes ❑ No ❑

Have you ever taken more than the prescribed dosage of any medication? Yes ❑ No ❑

Have you ever overdosed on drugs? Yes ❑ No ❑

Are your drinking/drug habits different on working days than on non-working days? Yes ❑ No ❑

Have you ever had problems with anger during drinking/drug use? Yes ❑ No ❑

Do drugs /alcohol help you sleep? Yes ❑ No ❑

Do you drink or use drugs while you are alone? Yes ❑ No ❑

Have you experienced family problems due to your drinking or drug use? Yes ❑ No ❑

Has drugs/alcohol use caused problems with your job or schooling? Yes ❑ No ❑

Have you ever attended alcoholics or narcotics anonymous? Yes ❑ No ❑ When? _____

What is your longest period of clean / sober time? _____ When? _____

Do you know why you relapsed? Yes ❑ No ❑ If yes, please Describe _____

_____

Have you ever been admitted to an in-patient SA facility? Yes ❑ No ❑

If yes, when: _____ Where: _____

Have you ever experienced any of the following before, during, or after drug/alcohol use?

Hallucinations	Yes ❑	No ❑	**Insomnia**	Yes ❑	No ❑
Blackouts	Yes ❑	No ❑	**Sweats**	Yes ❑	No ❑
Seizures	Yes ❑	No ❑	**Nausea**	Yes ❑	No ❑
DT's	Yes ❑	No ❑	**Weight loss**	Yes ❑	No ❑

Would you like more information about alcohol and/or drug abuse? Yes❑ No❑

NUTRITIONAL PATTERNS

Height: _____ Weight: _____ Are you on a special Diet? Yes ❑ No ❑

What kind? _____ Why? _____

When was the last time you exercised? _____

Do you eat less then three meals per day? Yes ❑ No ❑ Do you binge eat? Yes ❑ No ❑

If yes, describe: _____

Has your weight changed by more then 10 pounds in the past year? Yes ❑ No ❑ Up ❑ Down ❑

If yes, how much? _____

Do you have any concerns about your eating patterns? Yes ❑ No ❑

If yes, please explain _____

Client Signature _____ Date: _____

Parent/Legal Guardian _____ Date: _____

_____ Date _____

Therapist Signature/Credentials

ADDITIONAL INFORMATION

Is there anything else that you feel is important for your therapist to know about? If yes, please comment in the space provided on the back.

ADDITIONAL INFORMATION